Secretary would or could do in order to try to bring prices down; he would have to use his imagination.

I think it is appropriate for us to ask this kind of question before we buy into legislation that could so dramatically and negatively impact health care for our seniors. Restricting access could theoretically reduce lower prices if they were raised with some other program. That is the other downside to this legislation.

During the Finance Committee noninterference hearing, we heard testimony from Dr. Fiona Scott Morton, who is a Professor of Economics at the Yale School of Management. She made a couple of critical points. Individuals eligible to participate in Medicare Part D generate approximately 40 percent of prescription drug spending in the United States. The Secretary cannot negotiate a lower average price for such a large population; Medicare is the average.

So if it were somehow theoretically possible to reduce prices, they would have to go up somewhere else. That is the other point we established as well. There are many different organizations, including veterans organizations, that urged us to oppose this legislation because they understand that if you are somehow able to lower the prices for Medicare, they necessarily, arithmetically, have to go up somewhere else. The Veterans' Administration is one of those areas.

Let me quote from two letters, one received from the American Legion, which asks us to consider, and I quote:

. . . the serious collateral damage that would result from repealing the noninterference provision.

The VA is a health care provider, whereas Medicare is a health insurer. Any possible Medicare savings would likely result in a reciprocal cost to the VA. Compromising the noninterference provision by striking this section is not in the best interest of America's veterans and their families.

The American Legion is not alone. The Military Order of the Purple Heart sent a similar letter to the Hill. Bottom line here: Cost savings are the result of true efficiencies. Repealing the noninterference provision is just another way to shift costs at the expense of other consumers.

In conclusion, during this markup of this bill in the committee, I offered three amendments, each of which ensured important safeguards: No. 1, to prohibit cost shifting, as I mentioned, to entities such as Medicaid or veterans or the uninsured; No. 2, to require a certification of cost savings to Medicare beneficiaries if these negotiations were to occur; No. 3, a certification of four beneficiary protections: One, individual choice of a prescription drug plan; two, access to prescription drugs by prohibiting a government formulary or other tool to restrict drug access; three, guaranteed access to local pharmacies; and, four, no cost shifting to other payors, such as Medicaid, veterans or the uninsured. All three of these amendments were rejected. In fact, somebody called them a red herring. Well, restricting seniors' access to prescription drugs and increasing drug prices for all consumers are not red herrings, they are important issues which have not been adequately addressed in this legislation.

Repealing this noninterference provision would put the Government, not the individual in charge, and put seniors one step closer to a single Government-run designed formulary.

I appreciate and respect the goals of my colleagues. We all want to improve access to affordable health coverage. But with all due respect, they are wrong. A great deal of expert testimony and experience with Medicare Part D by millions of Americans has demonstrated they are wrong. So I urge my colleagues, when considering how to vote on this motion for cloture, to appreciate the fact that, first of all, there is a great benefit that is producing savings and is well appreciated by the American people; that there are organizations that are very much opposed to this, such as the VA, and that we would be very foolish, it seems to me, to adopt a piece of legislation such as this about which there is no consensus as to how the Secretary would utilize his authority to negotiate.

Mr. President, I ask unanimous consent to have printed at this point in the RECORD an editorial from the Wall Street Journal of today, April 18, 2007, which further amplifies the points I have made this morning.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal, Apr. 18, 2007]

BITTER PILLS

The Senate is scheduled to vote today on legislation to allow the government to negotiate drug prices under the 2003 Medicare prescription drug bill. Democrats and such liberal interest groups as AARP claim this would save money for seniors and taxpayers, but the more likely result is that seniors would find that fewer of their therapies are covered.

We opposed the prescription drug bill as a vast new entitlement, but there's no denying the program's innovation of using private-sector competition has worked far better than critics predicted. In the first year alone, the cost of Medicare Part D came in 30 percent below projections. The Congressional Budget Office calculates the 10-year cost of Medicare Part D will be a whopping $265 billion below original estimates.

Seniors are also saving money under this private competition model. Premiums for the drug benefit were expected to average $37 a month. Instead, premiums this year are averaging $22 a month—a more than 40 percent saving. Democrats don't like to be reminded that many of them wanted to lock in premiums at $35 a month back in 2003. No wonder recent polls find that about 80 percent of seniors say they're satisfied with their new Medicare drug benefits.

Democrats who opposed all of this private competition now say that government-negotiated prices will do even better. They must have missed the new study by the Lewin Group, the health policy consulting firm, which found that federal insurance programs that impose price controls typically hold down costs by refusing to cover some of the most routinely prescribed medicines for seniors. These include treatments for high cholesterol, arthritis, heartburn and glaucoma.

Supporters of federal price ''negotiations''—really, an imposed price—also like to point to the example of the Veterans Health Administration, which negotiates prices directly with drug companies. But it turns out that the vaunted VHA drug program has a few holes of its own. The Lewin study examined the availability of the 300 drugs most commonly prescribed for seniors. It found that one in three—including such popular medicines as Lipitor, Crestor, Nexium and Celebrex—are not covered under VHA. However, 94 percent are covered under the private competition model of Medicare Part D. Fewer than one of five new drugs approved by the FDA since 2000 are available under VHA.

Here's the real kicker: Statistics released March 22 by the VHA and Department of Health and Human Services show that 1.16 million seniors who are already enrolled in the VHA drug program have nonetheless signed up for Medicare Part D. That's about one-third of the entire VHA case load. Why? Because these seniors have figured out that Medicare Part D offers more convenience, often lower prices, and better insurance coverage for their prescription drugs. In short, seniors are voting with their feet against the very price control system that Democratic leaders Harry Reid and Nancy Pelosi want to push them into.

Of course, the greatest threat from drug price controls is not to our wallets, but to public health. Price controls reduce the incentive for biotech and pharmaceutical companies to invest the $500 million to $1 billion that is often now required to bring a new drug to market. If government price controls erode the profits these companies can earn to produce these often life-saving medications, the pace of new drug development will almost certainly delay treatments for AIDS, cancer, heart disease and the like. Congress is proposing dangerous medicine, and if it becomes law seniors may be the first victims.

Mr. KYL. I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Michigan is recognized.

PRESCRIPTION DRUGS

Ms. STABENOW. Mr. President, we have a very important vote we are going to take in a few minutes about whether we are going to be allowed to proceed—even to proceed—to a bill that would give the Secretary of Health and Human Services a very important tool to lower prices for prescription drugs.

With all due respect to my friends on the other side of the aisle, I hear very differently from seniors. First of all, they don't like, in Michigan, wading through 50, 60, 70 different insurance plans and all the paperwork to figure out what plan they are going to sign up for. They wanted us to go directly to Medicare which is, by the way, a Government-run program, one of the most successful in the U.S. Government.

They wanted us to be able to set up prescription drug coverage through Medicare. That wasn't done. Instead, we have this privatized system that was geared to making sure the industry would have the maximum amount of profit. That has been the focus, unfortunately, of this legislation, which

is why we would see, in the middle of a prescription drug bill for seniors, actual language that says: You cannot negotiate for lower prices.

Now, we have an opportunity to change that, to take that language away. What are we hearing? Well, we are hearing all kinds of things, all kinds of things. On the one hand we hear: This will do nothing for seniors. It will not help seniors. It will not lower prices. On the other hand we hear: It is going to do all kinds of things that are very terrible for people.

Well, it can't be both. What we have going on is an orchestrated effort by the industry to keep things the way they are.

If we were able to get better prices for seniors, there would not be that big gap in coverage that I guess some folks think the seniors like. Seniors in Michigan do not like that. After they have paid some $2,100 in drug costs, going into a gap where the average price has actually gone up, they have no help. This is a very different world I am hearing from, the people in Michigan, rather than what we are hearing from the industry and from others who support this plan the way it is.

We can do better than this Medicare prescription drug benefit. Today is the opportunity to decide whose side you are on, either on the side of the industry that is doing great under this bill, record profits, or you are going to be on the side of the seniors who are asking us to help them, whatever way we can, get the best deal for them by lowering their prices.

I wish to go through a few of the myths and the scare tactics that have been out there, and there have been many, there is no question about it. First of all, we are hearing from the industry now in big ads—by the way, I should say, $135,000 an ad a day—by folks who say this bill would not do anything. It is the Washington Post and another Washington Post. We go on and we can see all of the papers that we read. We have seen these ads in the Congressional Daily—daily, millions and millions of dollars.

I woke up this morning to an ad on television I have seen many times: The Medicare prescription drug benefit, yes, it is doing great for them. It is not doing great for our seniors.

Here is one of the things they are saying: that 89 percent of the folks oppose negotiation, if it could limit access to new prescription drugs. What they are saying is, they are telling people they are going to limit access to new drugs, they are not going to be able to do research anymore.

In fact, this bill would not limit access to prescription medication. I have to say, with all due respect, the industry spends about 2½ times more on advertising and marketing than they do on research. We have a long way to go. We could cut out a couple of ads. One ad for $135,000, if it was not done, I wonder how much medicine that would buy for people? This is not about doing away with research. We know that. CBO says that. We know that as a fact. This is not about taking away access to medicine for people.

We are being told it will have an effect on other purchasers. The Congressional Budget Office, I asked them to put in writing, after our Finance hearing, whether this bill would do that. CBO anticipates that S. 3—the bill in front of us, the Medicare Prescription Drug Price Negotiation Act of 2007 as reported by the Finance Committee—would not have an effect on drug prices for other purchasers.

Unfortunately, my good friends, the veterans for whom we work hard, whom we have raised health care dollars for, have been told something different. That is very unfortunate. It is not true. It is a scare tactic. This bill does not do that. CBO, in fact, has indicated it does not do that.

We hear something else that I think is very important. We hear: Well, we should not compare this to the VA; the Veterans' Administration negotiates group prices for our veterans. In fact, the average difference in price is 58 percent.

Now, some go up to as high as 1,000 percent, a 1,000-percent difference. On Zocor, there is a 1,000-percent difference. It seems to me there is a little room for us to negotiate for those on Medicare within that 1,000 percent.

But we are told no. The problem is that the VA, first of all, gets lower prices because they do not offer as many drugs; you cannot go to the VA and get the drugs you need, which is also not true.

From a presentation overview of the VA pharmacy benefit, in a presentation that was made, comparing apples to apples, now they have compared on the other side of this argument chemical compounds as opposed to actual drugs.

But the fact is, under Medicare there are 4,300 different drugs available, 4,300. Under the VA, they dispense 4,700—not 4,300—4,778 specific drug products, specific drug products which represent the chemical compounds that have been used on the other side of the argument.

In fact, in addition to that, if you go to the VA and if on the list, the approved list, there is not the medicine you need, you can ask for an exception to get the medicine you need. In addition to the 4,778 different medicines available from the VA, last year they dispensed prescriptions for an additional 1,416 different drugs so our seniors, our veterans were able to get what they needed from the VA.

When we hear concerns about veterans health care, with all due respect—I hear a lot about driving too far to get tests, waiting too long to see a doctor—I do not hear about not being able to get medicine.

The fact is, the VA dispenses more different prescriptions at a lower price than this privatized system, what I view as a dismantling of Medicare that has taken place through the prescription drug benefit that is before us.

What we have is the ability today to take a vote on proceeding to a bill that 87 percent of the American public wants to see us pass. And this is the AARP. Now, I find it very interesting, on the one hand, we have got all the folks representing the industry doing well under this bill, putting in ads, doing surveys, talking to us through the television and the radio saying that seniors do not want to negotiate the best price because of all these scare tactics.

But when the group who represents seniors, the AARP, speaks, they tell us 87 percent of voters want us to move ahead. This is a tool. This is giving the Secretary the ability to use that tool in a way that is responsible and will lower prices for our seniors. This is a motion to proceed.

I hope we are not going to see what we have seen, unfortunately, too many times this year, as we have—in the new majority—worked hard to change the direction of this country. I hope we do not see our efforts stopped from even moving forward to debate this critical piece of legislation. Eighty seven percent of the American public has some common sense. They are saying: What are you doing? What are you doing that you would not give the Secretary the ability to negotiate the best price?

I hope we will join together overwhelmingly and vote to give us the opportunity to consider this bill, to be able to move forward on a basic policy of common sense to help our seniors, people on Medicare, get the lowest possible price for their medicine.

The ACTING PRESIDENT pro tempore. The Senator from Texas.

Mr. CORNYN. May I inquire how much time this side of the aisle has remaining in morning business?

The ACTING PRESIDENT pro tempore. The Senator has a little over 20 minutes.

Mr. CORNYN. I see the distinguished ranking member of the Finance Committee here. I will speak briefly and then certainly yield the rest of our time to him.

There is a much larger question than has been addressed so far before the Senate this morning on this particular motion to proceed; that is, whether we are going to see the incremental growth of Government involved in intervening between decisions that should be made by patients in consultation with their doctors as a matter of individual choice. If, in fact, the advocates of this particular legislation are successful, it will be one step further down the road toward a single-payer system where the Government will decide what kind of health care we get and our family members receive rather than we as a matter of individual choice in consultation with our personal family doctor. That is a dangerous trend.

As my colleagues know, the Federal Government and Federal taxpayers pay for 50 percent of health care today. I am staggered by the suggestion that

the Federal Government can somehow do a better job than the private sector through choice and competition in setting drug prices. Rather than a negotiation, this is like a take-it-or-leave-it offer with a gun to your head. The consequences, if this legislation is successful, will be that seniors will have fewer choices, Government will have grown that much bigger and interfered much more in the private choices we should all make as a matter of personal choice. The irony is, this is one of the Government programs—I would say rare Government programs—that actually works better than we thought it would. As a matter of fact, I voted for the Medicare prescription drug bill in 2003, but I was concerned when some of the estimates that came out of the Congressional Budget Office indicated it would actually cost a lot more than we originally thought. But this is a good news story.

What I don't understand is why our Democratic friends want to ruin a good thing that 80 percent of seniors who have access to this prescription drug plan say they like and 90 percent of seniors eligible have signed up for, saving on average $1,200 a year. Why in the world would we want to mess up a good thing? I don't understand it, unless it is that incremental step toward a single-payer, Government-run health care system that would be a bad direction, rather than leaving the private sector to provide choices and competition, which improves services and lowers price.

Listening to some of my colleagues on the other side of the aisle, to paraphrase H.L. Mencken, they live in dread that somebody somewhere is actually making a profit in a private enterprise. I don't particularly care if shareholders in a company decide they want to risk their money to invest in a competitive enterprise to provide me and my family a service that I want and like and need and do it at a price that is lower and a service quality that is better than the Federal Government. The fact that they make a profit, good for them. That is what this country is built on. That is why our economy is the envy of the world.

Competition provided in the prescription drug benefit has forced costs down far below what was anticipated. In 2007, the average premium for the benefit is $22 a month—40 percent less than projected. We have heard the statistics before, but they bear repeating. The Congressional Budget Office new budget estimates that for the next 10 years, the net Medicare cost for the prescription drug benefit will be more than 30 percent lower than originally forecast, $265 billion. I have only been in the Senate for 4½ years, but I don't think I have ever seen or even read about a Government program that actually came in under budget at a lower cost than originally projected. For some reason—and it escapes me—some of our colleagues here want to change that, and that is a mistake.

One of the editorials in one of my newspapers back in Texas, the Austin American Statesman, writes:

> The incoming majority of Congressional Democrats, it seems, has a problem: a promise to fix something—the new Medicare drug program—that might not need fixing.

The basic point is this: We passed a prescription drug benefit that uses market competition to provide critical medications to seniors at costs much lower than projected. The results so far demonstrate the familiar principle that competition and choice could bring lower prices, something that should not surprise any of us. I must say, I am surprised at the magnitude of the benefit and the magnitude of the savings and the way this has lived up or, I should say, even exceeded expectations.

Today in the Wall Street Journal there is an article entitled ''Bitter Pills'' which I ask unanimous consent to have printed in the RECORD following my remarks.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit 1.)

Mr. CORNYN. This speaks directly to the comments made by the Senator from Michigan about the Veterans' Administration. Let me briefly read this paragraph:

> Supporters of federal price ''negotiations''—really, an imposed price—also like to point to the example of the Veterans Health Administration which negotiates prices directly with drug companies. But it turns out that the vaunted VHA program has a few holes of its own. The LEWIN study—

Which it alludes to earlier, a health policy consulting firm

> examined the availability of the 300 drugs most commonly prescribed for seniors. It found that one in three—including [the most] popular medicines as Lipitor, Crestor, Nexium and Celebrex—are not covered by the VHA.

Not covered. That is what the advocates of this legislation, I guess, believe is the ideal, to cover less drugs, and that is what the consequences of this legislation would be.

Let me read the last sentence:

> However, 94 percent of these drugs are covered under the private competition model of Medicare Part D. Fewer than one of five new drugs approved by the FDA since 2000 are available under the VHA plan.

If the right vote on this upcoming motion to proceed is to end the debate, it is not true that we haven't had debate. We are having the debate right now. But I believe the country would be better off, seniors would be better off, and choice and competition would remain available if we voted against the motion to proceed. That is how I intend to vote and urge my colleagues to do the same.

I yield the floor.

EXHIBIT 1

[From the Wall Street Journal, Apr. 18, 2007]

BITTER PILLS

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We opposed the prescription drug bill as a vast new entitlement, but there's no denying the program's innovation of using private-sector competition has worked far better than critics predicted. In the first year alone, the cost of Medicare Part D came in 30 percent below projections. The Congressional Budget Office calculates the 10-year cost of Medicare Part will be a whopping $265 billion below original estimates.

Seniors are also saving money under this private competition model. Premiums for the drug benefit were expected to average $37 a month. Instead, premiums this year are averaging $22 a month—a more than 40 percent saving, Democrats don't like to be reminded that many of them wanted to lock in premiums at $35 a month back in 2003. No wonder recent polls find that about 80 percent of seniors say they're satisfied with their new Medicare drug benefits.

Democrats who opposed all of this private competition now say that government-negotiated prices will do even better. They must have missed the new study by the Lewin Group, the health policy consulting firm, which found that federal insurance programs that impose price controls typically hold down costs by refusing to cover some of the most routinely prescribed medicines for seniors. These include treatments for high cholesterol, arthritis, heartburn and glaucoma.

Supporters of federal price ''negotiations''—really, an imposed price—also like to point to the example of the Veterans Health Administration, which negotiates prices directly with drug companies. But it turns out that the vaunted VHA drug program has a few holes of its own. The Lewin study examined the availability of the 300 drugs most commonly prescribed for seniors. It found that one in three—including such popular medicines as Lipitor, Crestor, Nexium and Celebrex—are not covered under VHA. However, 94 percent are covered under the private competition model of Medicare Part D. Fewer than one of five new drugs approved by the FDA since 2000 are available under VHA.

Here's the real kicker: Statistics released March 22 by the VHA and Department of Health and Human Services show that 1.16 million seniors who are already enrolled in the VHA drug program have nonetheless signed up for Medicare Part D. That's about one-third of the entire VHA case load. Why? Because these seniors have figured out that Medicare Part D offers more convenience, often lower prices, and better insurance coverage for their prescription drugs. In short, seniors are voting with their feet against the very price control system that Democratic leaders Harry Reid and Nancy Pelosi want to push them into.

Of course, the greatest threat from drug price controls is not to our wallets, but to public health. Price controls reduce the incentive for biotech and pharmaceutical companies to invest the $500 million to $1 billion that is often now required to bring a new drug to market. If government price controls erode the profits these companies can earn to produce these often life-saving medications, the pace of new drug development will almost certainly delay treatments for AIDS, cancer, heart disease and the like. Congress is proposing dangerous medicine, and if it becomes law seniors may be the first victims.

The ACTING PRESIDENT pro tempore. The Senator from Oregon is recognized.

Mr. WYDEN. Parliamentary inquiry: How much time remains on our side?

The ACTING PRESIDENT pro tempore. The Senator has 20 minutes.

Mr. WYDEN. It is my intention to go a little less than 10 minutes. I know the distinguished chairman of the committee is here as well, and I want him to be able to speak for our side.

Mr. President, I have always tried to work in a bipartisan way on health care. I voted in favor of creating the Medicare prescription drug program. I do not favor the Government running everything in health care. In fact, I have introduced legislation that would ensure that the government would not run everything. I believe it is important that pharmaceutical companies be successful in developing new products and therapies for America's seniors and for patients who are suffering. I believe it is time for the Senate to right a wrong. Outlawing the Government from any and every opportunity to negotiate lower drug prices for millions of seniors and taxpayers is an instance of special interest overreaching. Everybody else in America negotiates. Employers negotiate. Labor unions negotiate. Individuals negotiate. Everybody tries to be a smart shopper. Certainly Medicare, with 43 million people's interest on the line, ought to do everything it possibly can to be a savvy shopper.

It is especially important that the Government not give up the right to negotiate when single-source drugs are involved. These are drugs where there is no competition and no therapeutic equivalent. For many patients, a single-source drug is essentially the only drug available. Cancer drugs often fall into this particular category. What this means is, seniors who depend on these cancer drugs for their very survival often face bills of thousands and thousands of dollars. In my hometown, it can often cost something like $400 for a particular injection. We are talking about treatment with these single-source drugs for those who are suffering, say, from leukemia, from kidney disease. For the life of me, I don't see how it is common sense to say that we are going to give up every single opportunity for all time for the Secretary of Health and Human Services to try to negotiate a better deal for those seniors on drugs where there is no competition.

Senator SNOWE and I have worked for more than 3 years in a bipartisan way to address the most important concerns of our colleagues who have questioned this proposal. We believe strongly that we should not have price controls in any shape or form. Price controls clearly impede innovation and the development of new therapies. We should not do that. Chairman BAUCUS has ensured that price controls would not be allowed under the measure before the Senate today.

Senator SNOWE and I also believe strongly that there should not be restrictive formularies. These formularies—to use technical health care lingo—essentially involve a list of drugs to which seniors could get access. We should not restrict the access of seniors to medicines. Senator SNOWE and I have made that a priority for more than 3 years. Chairman BAUCUS has addressed that as well.

We don't have any one-size-fits-all, run-from-Washington kind of pricing regimes. All we have said is: Let's make sure we can negotiate when it is critically important. I submit, in every one of these budget letters—I know the history has been hard to follow; one said this, one said that—every one has indicated that there can be savings when there are single-source drugs involved in negotiation. I emphasize that. For certain cancer drugs, where seniors can be spending thousands and thousands of dollars, there is the potential for savings when the Secretary has a role there.

Not a single person in the Congress today can imagine all of the scenarios possible that may come up in 10 or 20 years, what new drugs there may be that could cure or treat health problems. There can be situations in the future where, for example, a different Secretary of Health and Human Services would use negotiating authority to get savings that can't be anticipated for drugs that haven't even been contemplated today. It doesn't make sense for the Congress to preemptively outlaw future savings. It especially doesn't make sense when the American Association of Retired Persons, in an RX Watchdog Report that looked at nearly 200 drugs including the most commonly used brand-name medications, has found that seniors very often need medicines that carry price tags that have gone up twice the rate of inflation. So we have older people getting hit—almost clobbered—with these costs which are going up more than twice the rate of inflation.

I and others have said we want to be sensitive to the question of innovation. That is why we have not supported price controls. But when you are talking about drugs, such as certain cancer drugs, and the interests of older people, let us not say, for all time, and in every instance, we are going to forsake the opportunity to negotiate.

Given that is possible to negotiate savings for seniors, if you stand up at a town meeting anywhere in this country and say, well, gosh, that is no big deal, I think seniors and taxpayers would say, try to get us the most value out of this program. This is a program I voted for and that I have always tried to look at ways to improve. I think there are plenty of ways under the leadership of Chairman BAUCUS and Senator GRASSLEY we can improve this program.

Certainly, it is still far too complicated. You almost have to be a legal wizard to sort through some of these forms and to be able to compare the possibilities you might have for your coverage. So there are other steps that can be taken in a bipartisan way. But we ought to have a real debate in the Senate on one of the most important pocketbook issues of our time. This is what people talk about in coffee shops, in senior centers, and in community halls all across the country.

I think the proposal Chairman BAUCUS has developed in this area makes sense. It does not go over the line and impede pharmaceutical innovation. It ensures we are going to be on the side of trying to stand up for seniors when it comes to those drugs, such as the cancer drugs I have discussed this morning, when they have trouble affording them.

I hope our colleagues will vote for the motion to proceed and a chance for the Senate to have a real debate rather than this abridged kind of discussion where only a handful of Senators can participate.

I thank the chairman of the Finance Committee for making sure this gets to the floor and, particularly, my colleague, Senator SNOWE, who has worked with me on this issue in a bipartisan way for more than 3 years. If we get a chance to proceed, she and I will be offering an amendment to strengthen the proposal still further.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, in Shakespeare's time, the poor had little access to medicine. In ''Measure for Measure,'' one of Shakespeare's plays, he wrote:

> The miserable have no other medicine, but only hope.

With the Medicare Modernization Act of 2003, we sought to give America's seniors, especially America's poorest seniors, something more than only hope. We sought to ensure that seniors had access to the affordable medicine they need.

When we crafted the Medicare drug benefit, we could only imagine how it would work. We really did not know. In some respects, our work was theoretical. We established a market-based approach in which any number of private insurers would compete to offer drug coverage. That was the foundation.

Even with a market-based design, we had tremendous concern that the market would not be able to offer drug coverage. As the former CMS Administrator said at the time:

> Private drug plans do not yet exist in nature.

We were starting from scratch.

In an abundance of caution, we went a step further than merely creating a market for drug coverage. We took what I am now convinced was a step too far: We tied the hands of the Secretary of Health and Human Services with what has come to be known as the ''noninterference clause.'' We eliminated the Government's ability to intervene to get fair drug prices for seniors. Today, we consider a bill to repeal a portion of that noninterference clause created by the Medicare prescription drug program.

What is the noninterference clause? The noninterference clause prohibits the Secretary of Health and Human Services from ''interfering'' with the negotiations between drug manufacturers and pharmacies and drug plan sponsors. Essentially, this provision bans the Secretary from doing anything that would affect the prices Medicare pays for drugs. Another prong of this noninterference clause prohibits the Secretary from creating a single, national formulary and from setting prices under the Medicare drug benefit. The legislation before us today, however, leaves that part alone. Those prohibitions remain.

Now the Medicare drug benefit is in its second year. Our theory that private plans would offer and deliver Medicare drug coverage proved accurate. It is working for millions of Americans. It is giving them more than just hope. But it is not perfect, and in some cases it still may not be giving seniors affordable drugs. We are here today because we need to do all we can to make sure it works well for everyone. Looking at the program today, the noninterference clause is an unnecessary hindrance. It ties the Secretary's hands.

Free markets are usually the best solution. But markets sometimes fail. In this program, American taxpayers are spending more than $50 billion a year to deliver a prescription drug benefit to seniors. We may on occasion need the Secretary to roll up his sleeves and get more involved in the program. We want Secretaries of HHS to be able to use the tools at their disposal. We want them to help shape the drug benefit into a strong and thriving program. It is time to untie the Secretary's hands.

The bill before us today does not change the market-based approach of the drug benefit. It does not change that at all. This bill is not the first step toward Government-run health care, nothing close to it. This bill is not the first step toward a single-payer health care system. No way. Rather, the bill before us today aims simply to improve and strengthen the drug benefit. It is our way of fulfilling our promise to provide Medicare beneficiaries with access to affordable medicines. We should not allow the Government to sit idly by while seniors continue to pay high prices or even go without their medicine. That would be a dereliction of duty. Congress created this benefit to give seniors access to affordable drug coverage. Now we need to make sure the prices seniors pay at the pharmacy are low, too. That is the goal of this legislation.

So let us build on the Medicare Modernization Act of 2003. Let us seek to give America's seniors something more than only hope. Let us ensure that seniors truly have access to the affordable medicine they need.

Mr. President, I yield the floor and reserve the remainder of our time.

The ACTING PRESIDENT pro tempore. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I have 12 minutes left; is that right?

The ACTING PRESIDENT pro tempore. That is correct.

Mr. GRASSLEY. Mr. President, I ask the Chair to please inform me when I have used 11 minutes.

Mr. President, we have a situation here where the latest argument has been that when we wrote the bill 4 years ago, providing pharmaceuticals for seniors under Medicare, we went one step too far by saying the Secretary of Health and Human Services should not interfere in plans negotiating drug prices.

Well, I want everybody to understand that we took this language from several different Democratic bills which had been introduced because I wanted this program to be as bipartisan as we could make it. So we had Senator Moynihan introducing President Clinton's bill in 1999 which had that language in it. We had a Daschle-Reid bill in the year 2001 which included that language. We had a House bill in 2001 which included that language. We had a Gephardt-Pelosi-Rangel-Stark-Dingell-Stabenow bill—Senator STABENOW now—which had this language in it.

So I want people to know that as to this language which they now think should not be in this legislation—the bipartisan approach—we took this language because we thought this would be one step further toward making this whole program bipartisan because we do not have enough bipartisanship in the Congress now. All of a sudden, everybody who thought this language was perfect language thinks this language—from Democratic pieces of legislation—ought to be struck out of this bipartisan bill. Obviously, as I said yesterday, and I say today, we have plans that are working. And if it ain't broke, don't fix it.

Mr. President, I have always been fond of jigsaw puzzles—spinning the pieces around, figuring out how the pieces of a puzzle all fit together, until you finally see the whole picture. This debate is a lot like working a jigsaw puzzle. I would like to have you take a look at a few of the pieces.

One piece is the House bill, H. 4, passed by the House. The House bill requires the Secretary to negotiate prices with drug manufacturers. The House bill also strikes the ban on Government price-setting. To date, the House authors have not explained why they wanted to authorize the Government to set prices.

The Congressional Budget Office said the House bill would not achieve any savings unless the Secretary was given the authority to establish a formulary or use some other tools to negotiate lower prices.

Let's look at another piece of the puzzle; that is, the bill before us, S. 3. The Senate bill authorizes the Government to take over Medicare's negotiations. It strikes the prohibition on Government interference in negotiations the prescription drug plans are doing today, negotiating with the drug companies to get drug prices down. The average cost of the 25 most used drugs by seniors is down 35 percent.

The Senate sponsors keep saying their bill ''begins the process'' for negotiation. But what about the negotiation that has been going on for 4 years under this bill? They say their language, by striking, is a step toward what they want.

As was the case in the House bill, H.R. 4, the Congressional Budget Office also says the Senate bill, S. 3, will not achieve any savings unless the Secretary establishes a national formulary or uses other tools to reduce drug prices.

So we have two bills, two pieces to our puzzle. But on Thursday night, in our Finance Committee markup of S. 3, we found a missing piece that helps us bridge the bills together and finally see the full picture of the puzzle.

On Thursday night, I offered an amendment that would prevent the Secretary from using preferred drug lists to limit access to approved prescription drugs. We have heard over and over again from our colleagues that neither H.R. 4 nor the Senate bill, S. 3, allows for a national formulary. But as all observers of the Medicaid Program know, States are not allowed to use formularies, but the courts have said States can use preferred drug lists. A preferred drug list is just like a formulary, only in sheep's clothing. It is a Government-controlled list of drugs a beneficiary can and cannot have; in other words, the Government saying what drugs you can use, not your doctor, or at least what drugs we are going to pay for. A national preferred drug list would have the same effect, then, as a national formulary.

So I thought: For all the talk about not allowing Government formularies, the proponents of S. 3 would embrace a provision banning preferred drug lists. If they really do not want to limit beneficiary access to drugs, it should have been an easy thing for them to support. So I offered that amendment to prohibit the Secretary from imposing a national preferred drug list. Much to my surprise, every Democrat in the committee voted against my amendment. When the proponents of Government negotiations defeated my amendment, they were, in fact, voting in favor of having the Government limit access to drugs. They voted for Government limits on access to drugs. They voted to have the Government tell beneficiaries which drugs they can have and which they cannot have, which is an intervention of Government between a doctor and a patient—that relationship we were working so hard to preserve when we wrote the bill in 2003.

We have the final piece of the puzzle allowing everything to fall into place.

What would H.R. 4 and S. 3 look like after they merged them together in conference between the House and Senate? Well, you can put two and two together and get an answer.

H.R. 4 requires the Secretary to negotiate drug prices and eliminate the ban on price setting. It is clear now that supporters of the Senate bill want the Government to set preferred drug lists because they voted against it when I offered that in committee, that the Secretary couldn't do that, preferred drug lists, which are just like formularies. They want the Government to determine what drugs seniors will be allowed to get coverage for. We have heard all this hooray about the VA and how they do things. Remember, the VA only pays for 23 percent of the drugs that seniors can get now under Part D.

The puzzle is complete. If we let S. 3 go to conference, we will have returned to us a bill that requires the Secretary to negotiate with drug manufacturers using price controls and a national preferred drug list. It couldn't be more clear.

We must not let that happen. We must put a stop to it and do it right here. Price control and a national preferred drug list are the tools they want the Government to have. They want to have the Federal Government take over Medicare prescription drug marketing, and that is absolutely the wrong thing to do. The Medicare drug benefit is working. ''If it ain't broke, don't fix it.'' It is a testimony to the idea that the private market works, that Government-run health care is not the answer.

They say Medicare doesn't negotiate. That is not true. Medicare is negotiating today, just the way we set it up 4 years ago to negotiate. Medicare is negotiating through the market clout of its prescription drug plans, and the market-based model for Part D is working. Costs are far lower than expected. CBO projections for Part D dropped by $308 billion—32 percent lower. That is the 2007 baseline compared to the 2006 baseline. Premiums for beneficiaries are 40 percent lower. Seniors overwhelmingly approve of the benefit.

So why do supporters of this legislation hate the Medicare drug benefit so much? They hate it because nothing could be more damaging to the idea of Government-run health care than Part D, the way we wrote it 4 years ago. It is a free market plan, and it is a market that is working, and that is not their plan for how health care should work. Their view is that Government knows best.

So what do seniors and all Americans have to look forward to if this Trojan horse attack succeeds in a Government takeover of prescription drugs? Seniors can look forward to fewer choices. Gone will be the days when seniors can select from various plans to find one that suits them. If this bill passes, seniors will get only the drugs the Government selects for them.

Do you want a Government bureaucrat in your medicine cabinet? All other Americans will see higher prices for their prescription drugs, experts testified before the Finance Committee.

I will go ahead and use up the remaining minute.

CBO has said that everybody else's prices will go up. We have reams of evidence showing that price controls and Medicare will lead to higher drug costs for everybody else. That means higher prices for veterans. That means higher prices for the disabled, pregnant women, and children on Medicaid. That means higher prices for small business owners and families. If we don't stop this bill right now, that is what we have to look forward to.

We can and should stop this bill in its tracks. Vote against Government-controlled drug lists, vote against Government setting prices, vote against Government restriction on seniors' access to drugs.

Mr. President, everyone should move beyond the simpleminded rhetoric of sound bites and see the full picture because sound bites don't make sound policy.

I yield the floor.

Mr. WYDEN. Mr. President, parliamentary inquiry: How much time does our side have remaining?

The ACTING PRESIDENT pro tempore. The Senator has 6½ minutes.

Mr. WYDEN. Mr. President, I have great respect for the Senator from Iowa, but I simply want to set the record straight with respect to a couple of points. The distinguished Senator from Iowa was talking about the House bill to a great extent. We are not dealing with the House bill. I want to be very clear what the Senate bill does.

All the Senate bill does is lift this restriction which bars the Secretary from ever having a role in negotiation. This bill—the measure that is before the Senate—does not take over the role of the private plans. The private plans would continue as they have since the program's inception: to sign the contracts, to conduct the various activities to make sure that seniors can purchase that coverage. There is no takeover of private plans, despite what has been suggested.

Point No. 2: In no way does the measure now before the Senate limit access to drugs for seniors. We have been told that under this particular measure, there would be huge restrictions with respect to seniors being able to get drugs, that there would be formularies established, a variety of prescriptive arrangements that would deny choice. That is not the case in this legislation.

Let's be clear. One, this is not the bill that is before the House. It is not the bill the House has acted on. Two, it simply lifts the restriction. Three, it doesn't take over the role of the private plans. The Secretary is simply complementing the role of the private plans. Four, under this particular measure, the Government would not limit access to drugs. There would be no restriction on drugs that seniors could get under this bill.

I only come back to the point I made earlier. This is about patients who are hurting. This is about those cancer patients, for example, who are taking drugs for which there is no competitive alternative, where there is no therapeutic alternative. Should we simply sit by and say that when they have to spend thousands and thousands for those cancer drugs—cancer drugs that are essential to their survival—are we going to say that we should give up any and every opportunity for the Secretary to try to negotiate a good price? I think we understand this is a straightforward issue. This is about whether we are going to have a real debate on one of the most important consumer issues of our time.

There are groups such as the AARP that have brought to the attention of every Senator what this means for their members. This is what people are talking about in coffee shops. They are talking about it in community centers. They are talking about it all across the country because they think when you have a program that has 43 million people, be the smartest shopper you possibly can.

We have the private plans out there already. The Baucus proposal—and I want to emphasize this—does not restrict the role of those private plans. It is going to go forward.

The question is, Should we make it possible for the Secretary of Health and Human Services to complement that role, to go beyond it and to say there may be some instances where we ought to negotiate? I voted for the Medicare prescription drug program. I do not support the idea of Government running everything in American health care, but it is time to right a wrong. This particular provision, which restricts the Secretary from ever negotiating, is an example of special interest overreaching.

The Senate ought to say today: We want to proceed to a real debate, not this abridged version where only a handful of Senators could participate. I am glad I could correct the record so that as we go to the vote, Senators understand that this bill is not the House bill, that this bill will not restrict the private plans, and it will not restrict access for seniors to medications. I urge our colleagues to vote for the motion to proceed.

Mr. FEINGOLD. Mr. President, one of the biggest flaws in the Medicare prescription drug benefit is that it does not adequately address the skyrocketing prices of prescription drugs. By denying the Government the ability to negotiate price discounts, the benefit actually takes away one of the best tools the Medicare Program could use in bringing down prescription drug prices.

That is why I am a cosponsor of legislation that would help address this fundamental flaw. The Medicare Prescription Drug Price Negotiation Act, S. 3, will remove language included in the Medicare Modernization Act that prohibits the Secretary of Health and

Human Services from negotiating prescription drug prices with manufacturers. The legislation goes a step further to require much needed data that would set the stage for additional legislation to strengthen negotiation in the future. This bill is something that the entire Senate should support, and I am disappointed that the Senate is being prevented from even debating, let alone voting on, this important bill.

When I talk about the new Medicare prescription drug benefit during my travels around my home State of Wisconsin, I continually hear from constituents about how they cannot believe that the Federal Government cannot negotiate with pharmaceutical companies about the prices of prescription drugs.

We need to help Medicare beneficiaries obtain affordable prescription drugs while still ensuring the Federal Government keeps prescription drug costs down. By lowering the underlying cost of prescription drugs offered through the Medicare Program, we will not only be helping beneficiaries save money, but we will also save the Federal Government money.

In a time of mushrooming deficits, skyrocketing prescription drug costs and an aging population, we need to be smart about how we use taxpayer dollars. If we are going to keep Medicare solvent, we need to take strong action to keep health care costs down, especially the increasing costs of the prescription drugs the new Medicare Program will be providing. This is the fiscally responsible thing to do, and it is also the compassionate thing to do as keeping drugs affordable ensures access to prescriptions for 43 million seniors.

I support this legislation, but I also support an even stronger step. It makes sense at this time to impose a mandate on the Secretary of HHS to negotiate lower prices. The Secretary should also have the right tools to negotiate effectively.

This bill doesn't address formulary or price control authority for the Secretary. An ideal bill would at least examine these issues closely, yet these are not mentioned. Formulary power and price controls in Medicare Part D should be debated in the near future, and the reports required in S. 3 will provide needed information for that debate.

So while I would like a stronger bill today, I support today's legislation because it is a giant step forward from where we are today. I hope my colleagues who are currently blocking this important legislation will reconsider their actions.

Mr. MARTINEZ. Mr. President, today I wish to discuss an issue that is on the minds of millions of seniors—prescription drug access and pricing. I am here to defend Medicare Part D and the importance of competitive drug pricing, because it works.

Prescription drugs play a vital role in our health care system. Thanks to technological and scientific breakthroughs in pharmaceuticals, Americans are living longer and more productive lives than ever before.

There has been a remarkable rise in pharmaceutical drug access to our Nation's citizens. A generation ago, there were nowhere near as many prescription drugs available—today, there are effective drugs on the market that help people do just about anything. From drugs that reduce blood pressure and fight uncommon bacterial infections, to others that lower stress and protect immune systems in the fight against cancer, there has never been a time in history like this.

Members of Congress have—over the last decade or so—made many efforts to extend prescription drug access to as many Americans as possible, specifically seniors. The expense has been significant, but so have the results. This improvement to prescription drug access is due in large part to Medicare Part D.

The Medicare Part D prescription drug program has been successfully reducing drug costs for seniors, and as long as we leave it alone and let it run as it was intended to, millions of Americans will continue to benefit—this was the goal and the goal is being met.

I strongly oppose any efforts to repeal the noninterference clause, and I encourage my colleagues to do the same.

My colleagues on the other side of the aisle, however, are moving to eliminate the noninterference clause—written into the Medicare Modernization Act, MMA—which, in layman's terms, means that some Members of Congress would like to give the Government the ability to negotiate drug prices on behalf of consumers. Proponents of this move believe that Government negotiation of drug prices would lead to lower prices for the millions of Americans in need of prescription drugs. Yet that is not the full picture. The reality is that there is no proof that eliminating noninterference would reduce costs for seniors in need of low-cost prescription drugs; in fact, there is a chance that this approach could limit senior access to certain types of prescription drugs—this is because, in Government negotiating of drug prices, competition will be eliminated. This is to say that certain drug companies will simply back away from the table and choose not to participate.

As you can see, Government negotiation will not benefit the consumer. It actually hurts the consumer because it limits what prescription drugs are available to them.

For that reason, I feel strongly that moving in this direction and having this debate is not the best use of the Senate's time. Why are we debating a program that has been successful in providing drug coverage for our seniors and has done so while costing less than anticipated? Our seniors have a choice in their plans, and they are pleased with those options. We should be using this time to focus on those who lack any healthcare options. I am talking about the millions of uninsured people in this country.

My colleagues and I should be talking about ways to give these individuals a chance for health care coverage. We need to further examine the Tax Code and fix its glaring inequities. The Tax Code needs to be unbiased; where you work should not affect how much you pay for health care coverage or what kind of health care options you have.

Why can't all American workers—whether they work for a Fortune 500 company or the local bakery they started from scratch—have the ability to purchase health insurance with pretax dollars?

My bill, the TEA Act, will allow just that. Why aren't we talking about that?

What about Senator COBURN's Universal Health Care Choice and Access Act—why aren't we talking about that? His bill will help transform our health care system to one that focuses on prevention and helps to reestablish the doctor-patient relationship, while also empowering individuals to choose where their care is delivered.

I encourage us to get past this time-consuming and unnecessary Part D debate and turn toward issues that are in need of solutions. From the uninsured, to future budget insolvency, to the global war on terror, there is plenty—of substance—to discuss.

Mr. ENZI. Mr. President, today I wish to speak in opposition to the bill currently before the Senate.

First I would like to briefly review the status of the new Medicare law that Congress passed in November of 2003. That landmark legislation enacted the first major benefit expansion of the program since 1965 and placed increased emphasis on the private sector to deliver and manage benefits. It created a new voluntary outpatient prescription drug benefit to be administered by private entities. The legislation also expanded covered preventive services and created a specific process for overall program review if general revenue spending exceeded a specified threshold.

I am pleased to be able to report that this new program is working. All across the country, seniors are expressing their approval of the new benefit. In my State of Wyoming, the new Part D prescription drug benefit has been a huge success. Last year, I traveled around Wyoming and visited with seniors in Cheyenne, Douglas, Sheridan, Casper, Powell, and Rock Springs. I talked to folks all over the State and told them about the new program as I encouraged them to sign up for it. I also talked to a few of the pharmacists in Wyoming that worked so hard to make this program a success. I believe I can speak on behalf of many of my colleagues in saying thank you to the thousands of pharmacists throughout the country that did so much to implement this great program.

Today, about 89 percent of Wyoming seniors are receiving prescription drug coverage, an increase of 16 percent from last year. They remember what it used to be like when they tried to get their prescription medications and they don't want to go back. I have received hundreds of calls and letters from Wyoming seniors who like the way things are and don't want Congress interfering with their prescription drug plan because it is working for them. Five separate surveys show that more than 75 percent of all beneficiaries are satisfied with the way the program works.

Not only are about 90 percent of seniors now receiving prescription drugs, the program is costing less than originally expected. When is the last time a government program cost less than was estimated? I came to Washington in 1997, 10 years ago, and I don't know that I have ever seen a government program that spent less money than we expected. Private competition is working better than we envisioned and it is saving seniors and the government more and more money every day. Why should we change that?

For some reason my colleagues on the other side of the aisle have decided they need to ''fix'' a program that isn't broken. We have implemented a plan that is working and before we change it, we need to be sure about what we are doing and the effect it will have on the program and the impact it will ultimately have on seniors from coast to coast.

The bill now before the Senate would strike the noninterference clause from the Medicare law. The ''noninterference'' language in the Medicare law prevents the Federal Government from fixing prices on Medicare drugs or placing nationwide limits on the drugs that will be available to seniors and the disabled. I support this language 100 percent. Decisions on what drugs should be available should be made by seniors and their doctors, not by some central committee in Washington.

Under the Medicare Part D law, each prescription drug plan has its own list of preferred drugs. Each plan's list is different—some are broader, some are narrower. Each list, however, has at least two drugs from each therapeutic class of medications and everyone can find a plan that is advantageous to them.

The ''noninterference'' bill before us is not only unnecessary, but it could also prove to be harmful to the health of our nation's seniors. The ''noninterference'' language protects seniors and the disabled from having the government decide which drugs their doctors can prescribe. It maintains the sacred relationships that seniors have with their doctors, who know best about what particular drugs are right for their patients. Patients support this language, and they want us to maintain it.

I would like to repeat, we have already implemented a plan that is working. Yet the majority party wants to ''fix'' the Medicare drug benefit. It is ironic to me that they use the word ''fix''—fix is exactly what this bill will lead to, the government ''fixing'' prices on drugs. It is not a bill about negotiating prices; it is a bill about fixing prices. As most Americans know, the Government doesn't negotiate in the Medicare program. It sets the prices that the Government will pay doctors and hospitals for serving seniors.

Setting the price is the same as price controls. And we saw what happened in the 1970s when we tried to control the price of gasoline. Do you remember the long lines at the gas pumps? Trying to control the price of gasoline was a complete disaster. Let's not experiment with giving government the ability to control the prices of prescription drugs.

Despite what some folks are reporting, the nonpartisan Congressional Budget Office has said over and over again that removing this language would not save the Government or seniors any money. It wouldn't save money because the Medicare prescription drug plans will have strong incentives to negotiate drug price discounts that would be as low—or lower—than anything the Government could negotiate. Additionally, many plans represent more people than Medicare, Medicaid, or the Veterans Administration, so the plans have greater purchasing power than the Government. To effectively negotiate, you need competing products, or you have to be willing to do without one of the products on which you are negotiating.

How many times does the Congressional Budget Office have to say that this bill will not save the Government any money before it starts to sink in? When will my friends on the other side of the aisle acknowledge that this bill will not save any money?

We do, however, know of something that will save the Federal Government and seniors money—competition among private plans. What has been proven to reduce costs—especially for seniors with low incomes—is the new Medicare drug benefit that we passed in 2003.

The competition among private plans is driving the cost of the program down. The average monthly premium has dropped by 42 percent, from an estimated $38 to $22—and there is a plan available in every state for less than $20 a month. So let me suggest letting competition work to drive the prices even lower instead of instituting government price controls that have failed in the past.

Also, because the program has choice, if the price of one plan goes up, beneficiaries can switch plans. It is important to remember that sometimes the prices will go up, because medical costs will go up as long as new technologies are invented that allow people to live longer, healthier lives.

Democrats want to change Part D to resemble the drug benefit program of the Veterans Administration. In the VA system, the Government sets a price on a drug it can get at the cheapest rate and limits or restricts access to those it can not get at cheap rates. As a result, the VA benefit excludes three out of four drugs available through Part D. Changing the Medicare Program to be as restrictive as the VA system is completely illogical.

Another thing about the VA system is that it can take a long time for new drugs to be included on the formulary—sometimes as long as 3 years. Let me repeat that. It can take as long as 3 years for new, life-saving drugs to be included on the VA formulary.

Lastly, the VA owns the whole system, so you have to order your drugs from them or you have to fill your prescriptions at one of 350 government-run facilities nationwide. In contrast, seniors signing up for a Medicare prescription drug plan can choose their plan based on the pharmacy they want to use to fill their prescriptions. As a result of all of these things, more than 1 million retired veterans have signed up for Medicare in the last year. I talked to many veterans in Wyoming and they all told me that they signed up for Medicare Part D so they could finally get the drugs they needed that they couldn't get from the VA.

Unfortunately, my colleagues on the other side of the aisle want to make the Medicare Program more like the VA program. They want to take away a senior's ability to choose. The real thing we should be talking about is how we can change the VA program to be more like Medicare Part D.

The mark also contains a few other provisions relating to the comparative effectiveness of prescription drugs—a study that determines whether drug A is better than drug B at treating a disease. The mark also contains a provision authorizing consideration of comparative clinical effectiveness studies in developing and reviewing formularies under the Medicare prescription drug program. No surprise here, but the Congressional Budget Office stated no savings will result because of this section.

This is the first step of a dance the Democrats want to do called ''cutting in on the relationship between doctors and patients.'' Decisions about what drugs patients should take should be made by doctors and patients. I think we should keep the Government out of the exam room.

To close, I would just like to remind folks of a few key points: (1) The Medicare Program is working. More seniors are getting the drugs they need at lower costs. (2) The bill before the Senate tries to ''fix'' something that isn't broken. (3) This bill will take away the choices seniors have about the drugs they use. (4) The Congressional Budget Office has stated several times that this bill will not produce any savings. (5) The bill tries to make the Medicare Program more like the Veterans program, but the Veterans program has

fewer choices than the Medicare Program)—that is why over one million veterans have signed up for the Medicare Program.

We don't need meddling for the sake of meddling or a new system conjured up for political convenience. Let's stop wasting the time of this important body and move to a bill that can actually do some good for the American people.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

Mr. MCCONNELL. Mr. President, I am going to proceed in leader time.

I rise in opposition to the effort to roll back the remarkable success of a prescription drug benefit that American seniors have been waiting for for decades and which millions of them now enjoy.

Republicans strongly oppose this effort to tamper with a program that is working extraordinarily well by every conceivable measure. In standing against those who would end it, we are standing up for the 32 million seniors in this country who enthusiastically support this terrific life-changing benefit.

But before I explain our reasons, I want to thank Senator GRASSLEY, who has been an extraordinarily effective leader on the Finance Committee, who has been right in the middle of this issue, going back to its formative stages in 2003, and has made a very articulate and persuasive case today for not tampering with this extraordinarily successful program.

Having said that, let's get right to the point. Republicans are on the side of seniors on this issue. There is simply no doubt about this. The only thing in question is why Democrats would even think about meddling with a drug benefit that has 92 percent coverage, 80 percent satisfaction, and which costs more than 30 percent—more than 30 percent—less than even the most daring bean counters estimated when we passed the bill.

Seniors who signed up for this benefit are saving an average of $1,200 a year on the cost of medicine, and taxpayers are saving billions—billions—$265 billion over the next 10 years less than anticipated.

Now, I ask everyone—anyone—in this Chamber: When was the last time a Government program came in under budget?

For those of you who may be watching on C–SPAN, that quietness was the sound of crickets and tumbleweed you just heard echoing from the Senate Chamber because I doubt a single Government program in modern history, let alone one this big and this important, has ever—ever—come in under budget. So it is a mystery why our Democratic friends would want to tamper with this Medicare benefit. If it isn't broke, why break it?

Now, the refrain we keep hearing from the other side is that we need competition, that drug prices will be even lower if we allow the Government to bargain for lower prices. Unfortunately, that is not true. The impartial Congressional Budget Office just sent us a letter saying there would be zero—that is zero—savings if Government stepped in and interfered with the current system. They sent the same letter to a Republican-controlled Congress last year.

The reason is simple. Prices have plummeted under Part D precisely because we have let private drug benefit managers, who already negotiate, into a Government drug program for the first time. They do the negotiating for us, and it is a good thing because they have much more leverage than we do. The three biggest drug negotiators, in fact, have four times as many members as the entire Medicare population.

Let me say that again. The three biggest drug negotiators have four times as many members as the entire Medicare population.

Look, you don't have to be a Milton Friedman to see that bigger negotiators are going to get better prices, and that is what we have right now with these drug benefit managers. Yet the other side wants to send a Medicare team to the negotiating table—a population with one-fourth the negotiating power. That is like sending a Little League pitcher up to the big leagues and handing him the ball for the big game. We already have aces on the mound, and they don't need any relief.

The point is, Republicans favor negotiation and competition, and our Democratic friends oppose it. Just look at the numbers. They speak for themselves. There is no way we could have achieved these savings if market competition and negotiation weren't at play. Secretary Leavitt said it pretty clearly just yesterday:

> There is rigorous, aggressive negotiation taking place right now.

That is why we are seeing such success and satisfaction with this program. But let's assume just for the sake of argument that price isn't an issue. Let's take price off the table for a moment. What about choice? What about choice? Here, too, Republicans are on the side of seniors. The VA model the Democrats are for some reason enamored with is inflexible and restrictive. It excludes three out of four drugs available through Part D, including some of the most innovative treatments for arthritis, high cholesterol, breast cancer, and other ailments. Veterans who want cutting-edge drugs like Crestor or Revlimid have to go elsewhere or they have to go without. The choice that 1 million of them have already made is to join the Part D Program—more than a third of them have signed up for the program over the last few years.

So let's sum it up. This seniors prescription drug benefit is popular. It is reaching millions of seniors. It is saving us billions of dollars. Veterans who have been using the program that our friends on the other side want us to imitate are signing up for this one in droves.

No wonder the former Democratic majority leader, Senator Daschle, and President Clinton's Health Secretary were all for creating a program such as Part D before suddenly our friends on the other side decided to oppose it.

This debate is hardly worth having. The facts are plain. Tens of millions of seniors in this country have a great drug benefit program—cheap, comprehensive, and easy to use. Republicans aren't going to let anybody fool with them.

I strongly oppose cloture on the motion to proceed and urge my colleagues to vote likewise.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Oregon is recognized.

Mr. WYDEN. Mr. President, I have a parliamentary inquiry: Our side has 2 minutes to close; am I correct?

The ACTING PRESIDENT pro tempore. The Senator is correct.

Mr. WYDEN. As one who voted to establish the Medicare prescription drug program and believes in bipartisanship, my message today to colleagues on the other side and on this side is this: We can do better.

There are patients who are enrolled in this program—enrolled right now—who are heart transplant patients and patients suffering from cancer, who, while enrolled in the program, are seeing their medicines go up hundreds of dollars—hundreds and hundreds of dollars in 1 month. They are enrolled in this program that I have voted for.

I say to my colleagues, let us look at ways to do better. The private plans are going to continue to take the lead. This measure does not preempt the work of those private plans. But in the name of those seniors who are enrolled in this program, who are seeing their bills go up hundreds of dollars a month right now, let us not pass up the opportunity to do better.

If we don't vote for cloture and go to this bill, we will not even have a debate in the Senate on an issue with such immediate life-and-death implications for our people, and I simply think that is wrong. I wish to make this program better. I wish to make sure we take advantage of every opportunity to do that.

I urge our colleagues, in the name of seniors who are enrolled in the program today and are having difficulty paying their bills, to vote for cloture. Let us have a real debate on this legislation.

I yield the floor.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.